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ABSTRACT

This paper focuses on change in health occupations education whose teachers are viewed as members of two professions (practitioners and teachers) and as members of two social systems (education and health care delivery). Following a presentation of a theoretical model of normative and personal dimensions of a social system, the paper examines empirical-rational, normative-reeducative, and power coercive change and the legal milestones and governance which have affected the social systems of education and health care delivery. Role expectations of health occupations teachers are cited, and a discussion is presented concerning how health occupations teachers must fulfill these role expectations by diagnosing educational needs as they relate to primary and secondary skills of learning and five life roles. Secondary skills related to occupational role expectations and the life role as renderer of services are discussed. Within this framework is described health occupations education and health care delivery in the contexts of today and tomorrow. Similarities in societal expectations for the educational system and health care delivery system are described. Also discussed are the role conflicts which result from being members of two professions and how health occupations teachers must learn to manage the conflict. (YLB)

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HEALTH OCCUPATIONS EDUCATION

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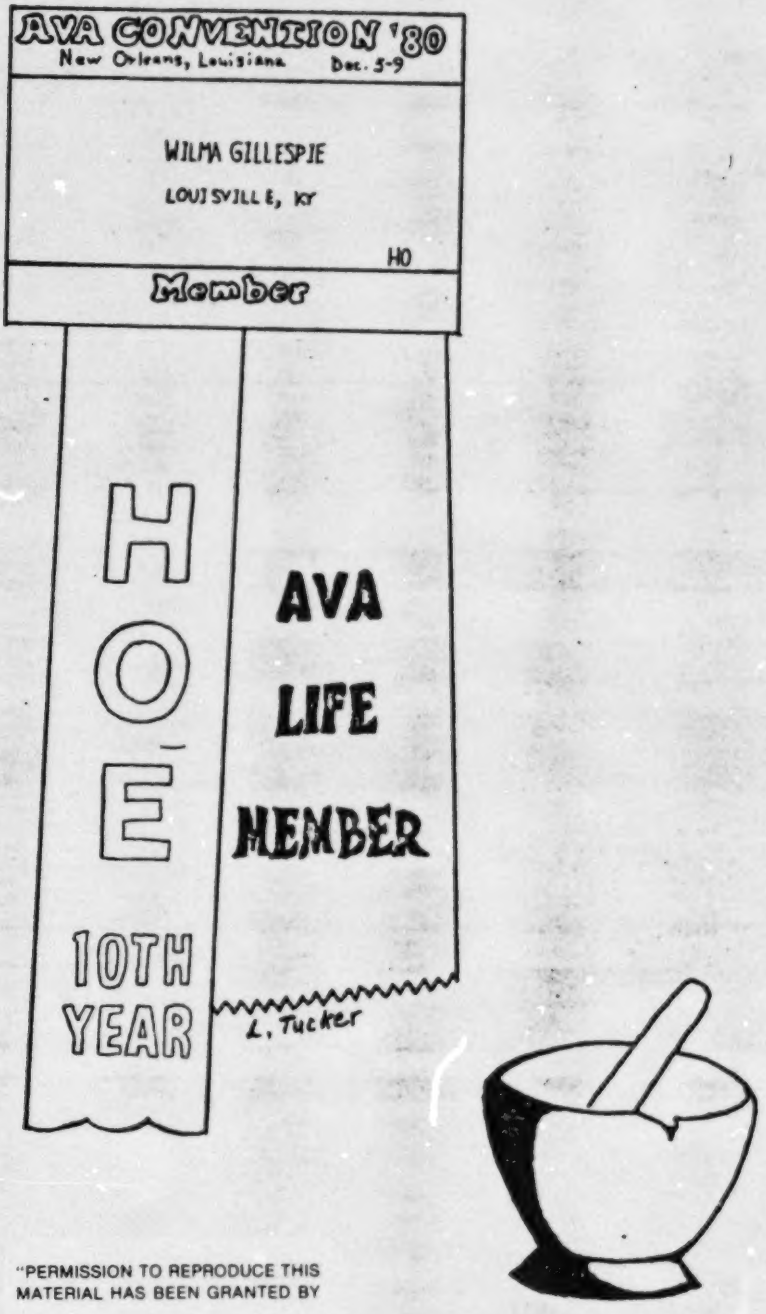
TODAY! AND TOMORROW!



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Presented at the Awards Luncheon
American Vocational Association
Health Occupations Education Division
New Orleans, Louisiana
December 8, 1980

HEALTH OCCUPATIONS EDUCATION

TODAY! AND TOMORROW!

- Introduction
- A theoretical model
- Legal milestones
- A historical perspective
- Health occupations education today
- Role expectations of teachers
- Occupational role expections
- Health occupations education tomorrow
- For both social systems
  - Organizational change
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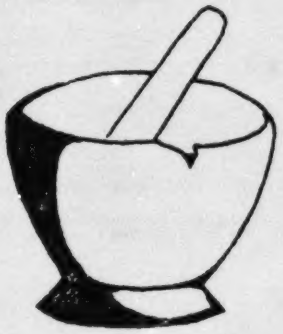


INTRODUCTION

Thank you, Dr. Pitman. The topic of this paper is "Health Occupations Education: Today and Tomorrow." It was developed on the following premises:

1. Health Occupations Education (a) pertains to education below the baccalaureate level, (b) is one of fifteen clusters in Vocational Education, and (c) as a cluster in Vocational Education is an integral part of career education.

2. Teachers in Health Occupations Education are members of two professions: (a) they are practitioners who hold credentials in health occupations and must meet the role expectations of agencies in the health care delivery system; and (b) as professional teachers they must meet the role expectations of educational agencies.

3. As professional practitioners, Health Occupations Teachers are members of two social systems - education and health care delivery. The social behavior of role encumbents in the educational system is based on role expectations of teachers; the social behavior of role encumbents in the health care delivery system is based on expectations for practitioners.

4. Change in either of these systems has implications for Health Occupations Education.

Based on a theoretical model of social systems and these four premises, this paper will be presented in four sections: (1) legal and other milestones in Health Occupations Education and Health Care Delivery; (2) a historical perspective; (3) Health Occupations Education Today; and (4) Health Occupations Education Tomorrow.

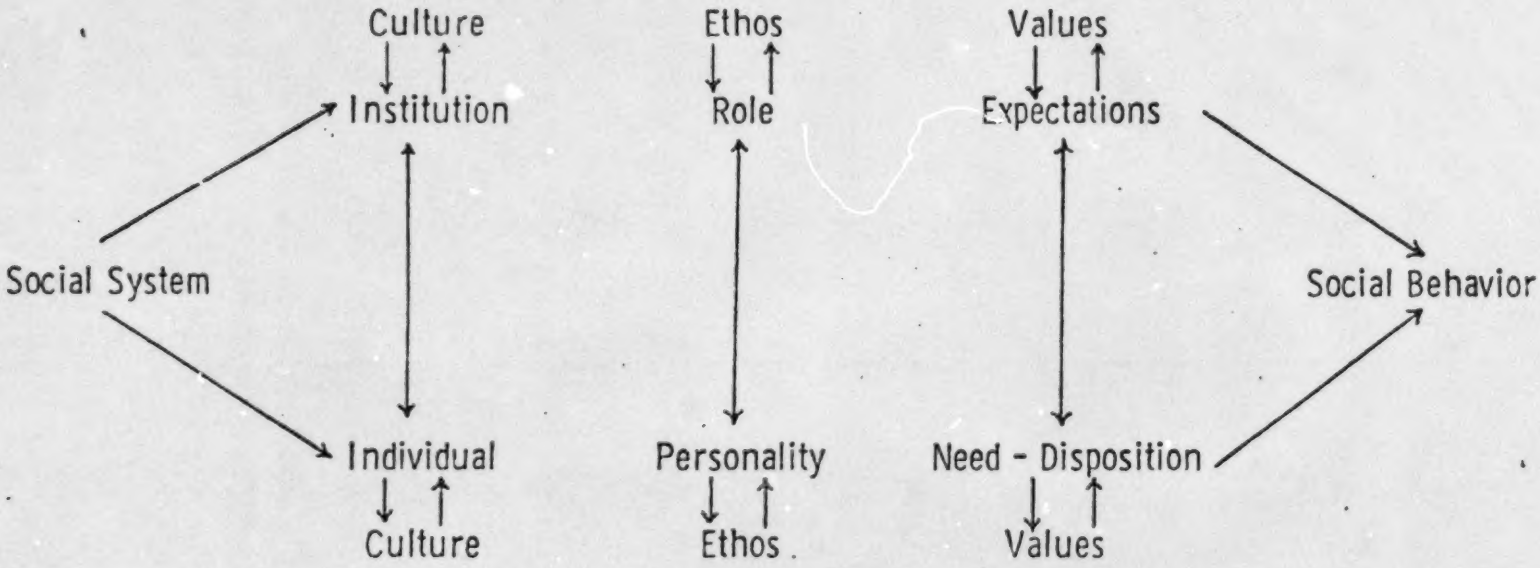
To focus these perceptions, think of the social behavior of role encumbents in Health Occupations as being in a crucible of change with a pestle of legal milestones and governance. These two concepts will be the thread that runs throughout this paper as the pestle of legal milestones and governance (control) is alternately energized and restrained as social, political and economic crises impact on the systems of education and health care delivery.

A THEORETICAL MODEL

Getzels and Guba (1951) have developed a model for viewing social behavior in a social system and the conceptual framework of this model has application for the social systems of education and health care delivery. The model incorporates the theory that society organizes institutions to serve its needs and behavior results from the interaction of the two dimensions of the model. (See Figure 1).

The normative dimension. Each of these social systems has certain needs. Maslow (1954) has described the needs of individuals as psychological or survival, safety, belonging, esteem, and self-actualization. The hierarchy has application for the needs of organizations in social systems. In other words, the organization has survival, safety, belonging and esteem needs. When the survival of the organization is threatened, efforts at meeting esteem needs (which are higher in the hierarchy) will usually be ineffective. An organization threatened with being phased out would not have an attentive employee audience for describing a reward system of service pins.

The needs of organizations serve as the basis for goals and change in societal expectations or crises can cause a shifting of the needs resulting in different goal direction. As the goals are defined, the tasks to achieve them are specified into relevant roles. Each role is assigned certain respon-



Jacob W. Getzels and Egon G. Guba, "Social Behavior and the Administrative Process", School Review, LXV (Winter, 1957), p. 423-41.

Figure 1. The Guba-Getzels Model of the Normative and Personal Dimensions of Social Behavior

sibilities and resources including the authority for executing the tasks. The roles in the organization are bound together with authority-responsibility relationships with the role serving as the norm for the behavior of the person fulfilling it. Persons must behave in more or less expected ways if they are to retain their legitimate place in the organization. The roles, organized around tasks to achieve the goals, are defined in terms of role expectations and therefore have certain normative rights and duties.

Expectations for roles are institutional "givens". The behavior associated with a role may be thought of as lying along a continuum from required to prohibited. It is this continuum which forms the basis of job descriptions. The roles are interdependent and interrelated and complimentary. To describe the role of a teacher's aide in the school system, one must describe the role of a teacher; to describe the role of a physician extender in the health care delivery system, the role of a physician must be described. Values of organizations also affect response to goal direction.

Personal dimension. Each role requires human persons to achieve the tasks and they are called role encumbents. This is what is referred to as the personal dimension of social behavior on the Getzels-Guba Model. Roles are occupied by real individuals and no two individuals are alike, differing in personality, needs, expectations and in ego strengths and ego separateness. Personality is defined by Getzels (1957) as "the dynamic organization within the individual of these need dispositions that govern his/her unique reaction to the environment." As was stated earlier, the needs of each individual are in an hierarchical order. This concept is important because one level of need must be met before goals addressed to the need above it can be achieved.

Organizational behavior in either of these social systems results from the interaction between the normative and personal dimensions. The values held by persons in organizations and the way these values are perceived can

influence interpersonal relationships between the providers and recipients of care (in the health care delivery system) and between the learner and the facilitator of learning (in the educational system).

Selective perception of role expectations can occur as role encumbents respond to roles. For example, two role encumbents, given the same description of role expectaticns (job description) may have different perceptions of the job. These perceptions may vary from the employer's expectations. This has implications for employment policies and practices and the length of the "orientation" period for new employees.

LEGAL MILESTONES IN HEALTH OCCUPATIONS EDUCATION AND HEALTH CARE DELIVERY

A. Health Occupations Education: In order to look at the development of health occupations education, one must look at the historical development of vocational education. The following legal milestones are significant.

1. The Smith Hughes Act of 1917 was the first major legislation for appropriating money for vocational education. It created the Federal Board of Vocational Education and provided funds for vocational education at the secondary level for agriculture, trade and industry and in home economics as well as training for teachers.

The development of health occupations education and its relationship to legislation has been reviewed by Holloway and Kerr (1969).

> Health Occupations Education at the vocational and technical level began with the development of practical nurses education. After the passage of the Smith Hughes Act, a few local practical nursing programs were established under the provisions of the act, which provided for trade and industrial education.
>
> In 1946 the George Barden Act, an amendment and extension of the Smith Hughes Act, provided additional funds which were used for the support of educational programs to prepare practical nurses (known as vocational nurses in Texas and California). Practical nurse education was given particular attention in the

Health Amendments Act of 1956, passed as Title II of the George Barden Act, which provided increased federal monies for matching purposes. Also the act required that those states participating in the use of federal funds employ a supervisor or consultant to provide leadership for practical nursing.

Thus, funding for practical nursing programs created a focus on health occupations education which through the years has had sustained interest, almost (in some instances) to the exclusion of other areas or components of the health occupations cluster.

2. Manpower Development and Training Act (1962) had as its purpose to train unemployed workers for available jobs and retrain underemployed workers for jobs with greater responsibility. Many practical nursing programs were developed under MDTA funding.

3. Vocational Education Act of 1963. The federal government made a total commitment to vocational education as reported by Calhoun and Finch (1976). The purpose was to maintain, extend, and improve existing vocational education programs. The act required (a) each state to have a state plan for vocational education, (b) state matching funds, and that (c) an advisory committee on vocational education be established in the United States Office of Education. This legislation also defined vocational education and spelled out provisions for approving work study programs for persons fifteen to twenty years of age. All of these provisions had implications for the growth of health occupations education.

4. Vocational Education Amendments of 1968 increased the number of members of the national advisory council on Vocational Education and provided for their appointment by the President. The council has published eleven reports. The seventh report addressed the issue of youth groups in vocational education and mentioned the development in some states of a new organization for students enrolled in health occupations education.

5. Title II EPDA Amendment of Higher Education Act of 1965 provided programs for inservice education and short term institutes for vocational education. Many health occupations education teachers, supervisors, and administrators took advantage of opportunities under the EPDA legislation.

6. Educational Amendments of 1972 defined post-secondary education and was significant in regard to the development of health occupations education.

7. Educational Amendments of 1974 provided firm support for career education. This legislation was based on the need for every person completing secondary school to be prepared for gainful employment according to ability and established (a) the office of career education in the U.S.O.E. and (b) a national advisory council on career education. The linkage of career education and health occupations education will be addressed later in this paper.

8. Public Law 94-142 dealt with placing learners with handicaps in the "least restrictive environment" and has implications for health occupations education.

Other milestones in health occupations education:

1. As was stated earlier, beginning with the Smith Hughes Act of 1917, practical nursing programs were organized under the trade and industrial education programs of most state departments of education. Education specialists who were appointed usually had occupational experience and professional licensure in nursing. As later legislation was passed and programs increased, most state departments of education appointed state supervisors of health occupations education.

2. Teachers and supervisors in health occupations education who were members of the American Vocational Association held membership in the Trade and Industrial Education Division. As the numbers began to increase, they

organized under the New and Related Division until the membership was sufficient for a separate division of AVA. Today we have elected the fourth vice president of the AVA Health Occupations Education Division and we have three organizations within the divisional structure. These are the (1) National Association of State Administrators in Health Occupations Education (NASAHOE), (2) Association of Health Occupations Teacher Educators (AHOE), and (3) Association of Health Occupations Teachers (AHOT). There will be others formed in the future.

3. Educationally prepared teacher educators of health occupations education have faculty appointments in at least one university in most states; all but a few of these teacher educators have occupational experience as well as credentials in health occupations.

4. The leadership organization for students enrolled in the trade and industrial education, Vocational Industrial Clubs of America (VICA), was formed while health occupations education was organized under trade and industrial education. Health Occupations Education Students had one option in student leadership organizations.

5. Health Occupations Students of America (HOSA), a leadership organization which provides students with access to the vocational student organization which related to the instructional programs in which they were enrolled has been developed. HOSA has (a) held its constitutional convention, (b) held three annual national leadership conferences, and (c) has state charters in 26 states and approximately 26,000 members.

6. HOSA (Health Occupations Students of America) has been included in the Policy Statement of the United States Office of Education for Vocational Education Student Organizations. The position statement also included the provision that leadership activities must be an integral part of the curriculum.

7. The by-laws of HOSA provide for a HOSA Foundation.

8. Two detailed analyses of the research in health occupations education have been completed.

8.1. Holloway, L. P. and Kerr, E. E. Review and Synthesis of Research in Health Occupations Education, 1969.

8.2. Gillespie, Wilma and Redford, Jeanette. Health Occupations Education: A Review of the Literature, 1980.

Since career education is now the law of the land, let's look at some of the significant persons and their contributions which have energized the pestle of governance in health occupations education.

> Goldhammer/Taylor-Career education is designed to capacitate individuals for five life roles through life-long learning; (1) producer of goods or renderer of service; (2) member of a family group; (3) participant in the social and political life of society; (4) participant in avocational pursuits; and (5) participant in the regulating functions in aesthetic, moral and religious concerns. There are four basic objectives of the career curriculum: (1) social effectiveness; (2) economic productivity; (3) self-realization; and (4) moral responsibility.
>
> Swanson - Career Education provides opportunity to exit and reenter the education system and career patterns.
> Career Education provides one hundred percent placement.
> Success related outcomes of the educational process are essentially Non-Cognitive; they relate to social relations, to the socialization process and to the status-transmitting influence of work roles.
>
> Hoyt-The school has the responsibility to stick with learners until they have their feet firmly on the next of their career ladders; to help them get back on the ladder if their feet slip; and be available to help them onto a new ladder at any point in the future that one proves to be too short or unsteady.
>
> Calhoun and Finch-Defined nine levels of Career Education based on the degree of comprehensiveness. Levels one through five are present oriented while levels six through nine are future oriented. Beginning with level six, the process of decision making throughout the occupational hierarchy is emphasized. Level seven is decision maker oriented while the eighth level in the degree of comprehensiveness is decision implementer oriented. Level nine, the highest level of comprehensiveness, is oriented toward public policy decision making. These nine categories of career education based on the degree of comprehensiveness are explained in Table 1.

TABLE I

NINE (9) CATEGORIES OR LEVELS OF CAREER EDUCATION (BASED ON DEGREE OF COMPREHENSIVENESS)

Level	Degree of Comprehensiveness (Focus)
1.	(A) Performance of manipulative skills, activity oriented, present oriented, and undisciplinary.
2.	(A) As State Above (B) + development of cognitive and affective learnings essential for successful employment in one or more jobs in an occupational cluster. Job oriented and present oriented.
3.	(A) As Stated Above (B) As Stated Above Job oriented and present oriented. Difference is that a multi-disciplinary approach provides manipulative skills and related cognitive and affective learnings. Entire curriculum of the school is integrated, with all learning experiences presented in an occupationally relevant manner.
4.	(A) As Stated Above (B) + cognitive and affective competencies needed for employment in a cluster of occupations. +consideration of relationships between the individual's "on the job" existence and his/her life as a worker and a citizen (qualities of leadership and citizenship and of constructive use of leisure time). Taught in a undisciplinary mode.
5.	(A) As Stated Above (B) As Stated in Level 4 + Competencies needed for family living Participation in community activities +Aesthetic appreciations It is learner oriented. Differs from level 4..A multi-disciplinary approach is used. Learning experiences are integrated among several subject matter areas.
6.	Development of the individual's capabilities for coping with the present and the future. Preparation for employment in existing jobs as well as in occupations that have not yet emerged, in a society that does not yet exist. Less emphasis will be given to psychomotor skills and more emphasis to decision-making competencies involving all levels of the occupational hierarchy. It is learner oriented and multi-disciplinary. Learning experiences organized around problems of social and economic change.
7.	(A) Individuals in relation to their physical, social, and technological environments. Restructuring the learning and work environments to be supportive of life styles in a pluralistic society. (B) Decision-maker oriented. (C) A technology of behavior will provide insights that support behavioral outcomes.
8.	(A) As Stated In Level 7 (B) Decision implementer oriented Learning experiences aimed at development of leadership behavior that recognizes the need to provide learning and work environments that reinforce life styles and evolving world views. (C) As Stated In Level 7
9.	Individuals in relation to their total environment, including the political environment. Public policy-maker oriented. Development of public policies related to the work ethic, pluralism, welfare, support of education. Highly future oriented. A combination of behavioral technology and public policy making technology will support individual life styles in a pluralistic environment within the framework of evolving world ideas.

From Calhoun, Calfrey C. and Alton V. Finch, Vocational and Career Education: Concepts and Operations. Belmont, California: Wadsworth Publishing Company, 1976.

T. H. Bell - stated that congress made career education the law of the land.

B. Health Care Delivery: The health care delivery system responds to crises and change and role expectations are redefined in relation to the change. Older practitioners can recall when all crutch walking instruction was done by the nursing staff and penicillin injections were done by medical interns. A greater demand for dental care, due primarily to increased "dental awareness" and to third party payment systems, has expanded the role of the dental assistant practitioner to include a number of tasks that were previously reserved for the dentist. Other examples are the changes in role expectations which resulted from Medicare and Medicaid.

The Health Professional Education Assistance Act of 1976 contained elements for change to meet such national needs as providing more primary care practitioners and improving health services. Section 1123 of the Act provided for the establishment of qualifications for health personnel under the Medicare Program. Methods were developed to determine the proficiency of individuals who did not meet formal requirements for performing the duties of various types of health care. This obviously had implications on the philosophy of health care, as well as organizational change, role legitimation and recognition, and program development.

A HISTORICAL PERSPECTIVE

Historically, health occupations practitioners who become teachers have followed the traditional roles of public school teachers and have placed the emphasis on the "teaching" part of the teaching-learning process in relation to time, school calendar, and frequency. When these concepts were used in teaching occupational role expectations, both the normative and personal dimensions of behavior were affected. Some examples of the teaching-learning practices of the past are:

1. Recording 18 hours of pharmacology or having a three-week rotation in a periodontic practice, or "scrubbing" for 25 deliveries. These standards or essentials were also requirements of accrediting, licensing, or certification boards.

2. Having learners do procedures a certain number of times or frequencies. The learner may actually have met the teacher's expectation (in terms of the standard) on the first evaluation but was told "You did fine; but you need to repeat this procedure a couple of more times before I can check you off." This resulted in procedural-oriented learner expectations and the number of procedures which a learner could do was frequently related to levels of workers or workers with procedure titles such as "Medicine Nurse."

3. Exercising the "sink or swim philosophy" that the best way to learn is to do it regardless of the number of attempts made in trial and error. For example allowing X-ray students to make X-rays with little or no instruction.

4. Recording in quantitative terms, dealing with numbers or times, as they relate to judgments in meeting expectations in evaluation can lead to perceptions of worth. For example, a worker says, "I did six patients

today; the student only did one." The implication is that one is more valuable to the organization than the other. The result is that quantitative measurements rather than qualitative judgements are used as indicators of worth in relation to meeting role expectations.

5. Tasks to achieve the goals of the organization (as in the care of a single patient) are related to the perception of prestige levels in the authority-responsibility hierarchy. This can generate statements like, "I'll be glad when I can give medications so I won't have to give baths anymore."

6. Information gate-keeping relative to health care information, care planning, and patient education was practiced by some super-ordinates in regard to subordinates. This was frequently perceived as a "control" mechanism often related to perception of power and/or prestige. Decision making by each role encumbent consisted of a valuing as well as an informational dimension. If the information was perceived as having little or no utility in terms of value, the behavior of the role encumbent was often affected.

HEALTH OCCUPATIONS EDUCATION TODAY

For purposes of this paper, it would not be productive to describe all of the forces that have energized the pestle in the crucible of change. Through legislation (mentioned earlier) and trends (such as competency based education and performance based teacher education), the focus was put on the learner and the learning process through emphasis on life-long learning, equal opportunity, self-direction and assuming responsibility for personal learning, stating expectations in terms of learning not teaching, and directing efforts toward quality control by teacher certification and standards for teacher education programs.

Teachers in programs of health occupations education today are subject to the societal expectations for teachers and the societal expectations related to health care practitioners. This paper will attempt to focus these expectations within the framework of a definition of educational need as it relates to (1) life long learning for five life roles, and (2) primary and secondary skills for living. The latter will address the roles of health occupations teachers and the modes of occupational expectations.

A DEFINITION OF EDUCATIONAL NEED

An educational need is defined as the difference between the present and desired level of knowledge, behavior, or competency. Health occupations education teachers are expected to determine these needs of individual learners. The educational need may be in (1) cognitive, personal, or moral development, (2) basic human needs, (3) the several dimensions of maturation, (4) life roles, or (5) primary and secondary skills for living. This paper will address the latter two.

1. Life-long Learning for Five Life Roles. The five life roles described by Goldhammer and Taylor (1972) are: (1) producer of goods or renderer of services; (2) member of a family group; (3) participant in the social and political life of society; (4) participant in avocational pursuits; and (5) participant in the regulating functions in aesthetic, moral, and religious concerns. The life-long learning process should have as its goal to nurture the ability of learners to interpret life situations and correspondingly make relevant decisions about roles in life careers based on a set of values which they choose, prize and act upon. To accomplish this goal both primary and secondary skills are required.

EDUCATIONAL NEED

PRIMARY SKILLS

SECONDARY SKILLS

DIMENSIONS OF MATURITY

PERSONAL, COGNITIVE, or

MORAL DEVELOPMENT

1. Recording in time or frequencies

2. Doing procedures certain number of times

3. trial and error learning (sink or swim)

4. Recording in Quantitative terms

5. Perception of prestige levels

6. Information gate-keeping

2. Primary and Secondary Skills. The concept of primary and secondary skills was identified in the 1969 yearbook of the Association for Supervision and Curriculum Development, by Rubin:

> Solving an equation, repairing a faucet, performing a piano sonata, and driving a golf ball can all be conceived of as secondary skills. Underlying the secondary skills and defining the whole realm of human potential are the primary skills by which people adapt to and master life situations.

The following primary skills were identified by the writers in the Yearbook (1969) as skills for living:

A. Skills of productive thinking, (problem solving and decision making). Problem solving as described by Bailey and Claus (1975) involves: (1) defining the problem by (a) identifying a discrepancy between needs, purposes and goals and assessment of what is or could be, and (b) recognition of a desire or need for change; (2) defining a framework for problem solution; (3) stating decision objectives and performance criteria; (4) generating and listing alternative solutions; (5) analyzing options; (6) choosing an option; and (7) controlling and implementing action.

The decision making process in the nine categories of career education based on the degree of comprehensiveness as described by Calhoun and Finch (1976) was mentioned earlier. Decision making as a process consisting of four stages of awareness, design, choice, and action was described by Stufflebeam et al. Following the awareness that a decision needs to be made (awareness), the alternatives for making a choice must be developed, the criteria for weighing the alternatives must be determined, the decision rules defined, and timing for the decision must be estimated (design). Information on each alternative must be obtained, the decision rules applied and a choice of one of the alternatives made (choice). The awareness, design, and choice are followed by fixing responsibility for implementing the selected

alternative (action).

The decision maker must have available useful information in order to reduce uncertainty and judge decision alternatives. Making a decision involves the decision maker in both the informational and valuing dimensions related to the process of decision making.

The ability to reason necessitates skill in acquiring, understanding, creating and using knowledge and information. New information must be processed by the learner, rearranged in his/her own intellectual symbols, and added to his/her conceptual repertory. This information must be internalized by learners in relation to how this will affect their behavior in life situations.

B. Skills of Emotional Management. Each individual engages in need-meeting behavior of life situations. Growth in the several dimensions of maturity connotes growth toward self regulation of behavior. The skills of emotional management are directed toward life-coping: (1) the management of conflict in the relationships of self to others and to the environment; and (2) achieving a careful balance between conformity and independence. These skills were described by Rubin (1969). As individuals are less able to engage in self-regulatory behavior by making relevant decisions for themselves they become more dependent upon external regulation and thus more open to deep seated conflicts. The ability to cope comes from successful solving of past experiences. Persons who have not learned what values to prize, choose and act upon cannot test different solutions in life situations against their beliefs and values. Thus the person is unable to reduce the conflict to a point where it is manageable. As Rubin (1969) has stated "conformity seems to be the lesser of two evils and is the behavior in life experiences which have high risk to the self concept."

C. Skills of Compassion and Competence. Competence in all domains of human knowledge is desirable but it is not sufficient of itself. The educated person understands the humaneness of human beings and does not allow technical skill to destroy compassion. Skills of competency must be accompanied by a growing sensitivity for compassion. Competent humans are characterized by compassion: (1) by the ability to interpose reason between impulse and action, (2) by an open-mind, and (3) by capacity to fulfill their potential. Competent humans periodically and systematically renovate their conceptual framework, using new experiences and insight to correct their misconceptions. Similarly the competent human refines old skills and cultivates new ones as life situations demand. As the competence skills increase compassion should increase accordingly. This is necessary so that competence in skills in one area of human relationships is not accompanied by diminishing compassion for those who have not achieved this level of competence.

D. Value Clarification Skills. Value clarification is based on the approach formulated by Raths, Merrill, and Simon (1966) who were not concerned with the content of values but the process of valuing (choosing, prizing and acting):

Choosing: (1) freely, (2) from alternatives, and (3) after thoughtful consideration of the consequences;
Prizing: (4) cherishing, being happy with the choice and (5) willing to affirm the choice publicly;
Acting: (6) doing something with the choice; and (7) repeatedly, in some pattern of life.

Every day students meet life situations which call for thought, problem solving, decision making and action. Every action taken and every decision made is based on the internalization of information, the perception of self and others and on beliefs and values. In the decision making process, more alternatives make choice more difficult. When choices are in-

creased, conflicts in values are more apt to occur. Raths, Merrill, and Simon summarize these observations like this:

> The critical test of a person's insights is whether they provide him with a set of beliefs about himself in relation to his social and physical environment which are extensive in scope, dependable in action, and compatible with one another.

The primary skills (productive thinking, emotional management, compassion and competence, and value clarification) pertain to life roles described by Goldhammer and Taylor (1972) of (1) member of a family group, (2) participant in the social and political life of society, and (3) participant in the regulatory functions in aesthetic, moral and religious concerns. The secondary skills as described by Rubin (1969) pertain especially, but not exclusively to the life roles of (1) producer of goods or renderer of services, and (2) participant in avocational pursuits. This paper will not address the latter.

Secondary Skills. Students enrolled in health occupations education must acquire the knowledge needed to fulfill occupational role expectations (as renderers of services). Historically, occupational education has put great emphasis on the skills and expectations of the job itself. However, four modes of occupational expectations have been identified in research by Hofstrand (1975). These modes are based on the relationship that a worker has with (1) himself or herself, (2) other persons on the job, (3) other persons outside the job, and (4) the job itself.

> The first mode involves the relationship that a person has with himself through his job or occupation and the expectations may be affective in nature such as feelings of competency or achievement.
>
> The second mode involves the relationship that a person has with other persons who are outside the job environment. Such persons include family, friends, neighbors, clients, customer, and society as a whole. Expectations relating to glamour and altruism were included here.

> The third mode involves a worker's relationship with other persons within the work environment such as fellow workers, subordinates, and supervisors. Within this mode, the job serves as a vehicle through which interpersonal relationships occur such as comradeship, supervision, and authority.
>
> The fourth mode involves a worker's relationship to the inanimate job itself. This mode deals with the job as an end product, and expectations tend to be physical and tangible in nature. Renumeration and autonomy are examples within this mode of occupational expectations.

Hofstrand concluded that students in the research sample expressed stronger feelings and placed more value on occupational expectations within the first mode (relationship of self through the job) than in the second mode (relationship of persons within the work environment), and the third (relationship of persons within the work environment) over the fourth (relationship to the job itself). From these data, research conclusions tend to indicate that young people appear to be placing greater value on their relationships with themselves and other persons and lesser values on the job in and of itself.

Employers in rating a score card for vocational education frequently give vocational education high marks on the expectations related to the job itself; however, they frequently state that vocational education has not met as well as the other three modes of occupational expectations and state "send me employees with a good attitude toward work and I'll teach them the skills."

The primary skills (productive thinking, emotional management, compassion and competency and value clarification) cannot be divorced from the secondary skills to meet occupational role expectations. Both the primary skills and secondary skills are necessary to lead productive, rewarding, satisfying life roles. They may be thought of as the life skills which are necessary to fulfill all the role expectations of the life careers.

These four modes of occupational expectations from the basis for learning related to understanding authority-responsibility relationships.

ROLES AND ROLE EXPECTATIONS OF HEALTH OCCUPATIONS TEACHERS

Developing helping relationships with learners so that these educational needs can be met requires a different focus on the teaching learning process and thus on the role expectations of health occupations teachers.

Deever and Smith (1973) have identified five areas of instructional competence for the roles of the teachers in health care. Additionally, an 18 scale instrument for the evaluation of teacher effectiveness has been developed, field tested, and disseminated through workshops throughout the nation. By using this instrument, areas of instructional competence can be evaluated for the role of the instructor as (1) a director of learning, (2) advisor of students, (3) facilitator of human relations, (4) member of the instructional staff, and (5) member of a health care specialty. As director of learning, teachers must plan, implement, and evaluate learning experiences around the four modes of occupational expectations.

Each role in the health care delivery system has certain role expectations. Role expectations have been defined by Meries (1975) as:

> ...those rights and duties, privileges, and obligations and those prescriptions that delineate what persons should or should not do under various circumstances in a particular role in a social system.

The words "various circumstances" in the definition affect role expectations in organizations in the health care delivery system in four significant ways:

Role expectations can change:

1. <u>During different times of the day</u>. For example, in some health care agencies, the pharmacist dispenses medicines until 5:00 p.m. When

ROLE EXPECTATIONS

" THOSE RIGHTS AND DUTIES, PRIVILEGES, AND OBLIGATIONS AND THOSE PRESCRIPTIONS THAT DELINEATE WHAT PERSONS SHOULD OR SHOULD NOT DO UNDER VARIOUS CIRCUMSTANCES IN A PARTICULAR ROLE IN A SOCIAL SYSTEM."

MERIES

medicines are needed after this time, the task may be assigned to another role encumbent. Similarly, the criteria of criticality and frequency in determining which level of worker will do certain procedures depends, in some instances, upon the rurality/urban factor;

2. As the decision setting changes. A decision setting has been described by Stuffelbeam et al (1972) as "the total set of environmental circumstances governing both analysis and choice." The two continuua used in describing the decision setting are (a) the degree of change, and (b) amount of information grasp. Both are germane to "various circumstances" in health care delivery.

(The continuum of degree of change) in this context relates to the degree of scientific complexity in patient/client situations and is used to determine which role encumbent will be the decision maker. The degree of change may include one or all of the following criteria: (a) stability in the patient/client's clinical state, (b) predictability of change, (c) closeness of consequences of change (long-range in days or months, or short-range in seconds, minutes, or a day), (d) complexity of care measures and the information needed to judge the decision alternatives relative to the change in complexity, (3) the nature of the helping relationship and helper/helpee behaviors, and (f) the type of instruction required. For example, emergency paramedical personnel (as role encumbents) must obtain information for patient assessment in given circumstances and relay this information to a site where the physician (decision maker) uses the information to judge decision alternatives.

The continuum of information grasp has to do with information needed to make decisions and the ability of the decision maker to use the information. Situations in "various circumstances" exist in the health care delivery system where the information is obtained by one role encumbent for another role

VARIOUS CIRCUMSTANCES

1. DURING DIFFERENT TIMES OF THE DAY.

2. AS THE DECISION SETTING CHANGES.

3. WHEN THE AUTHORITY TO TAKE ACTION.

   BY JUDGING ALTERNATIVES IS DELEGATED.

4. FOR EACH RECIPIENT OF CARE.

encumbent who is the decision maker. Medical laboratory technologists, medical assistants and electro-cardiograph technicians obtain information which is used by other role encumbents who must decide to take or not to take action.

3. When the authority to take action by judging alternatives is delegated. Evaluation has been defined by Stufflebeam and the Phi Delta Kappa Committee (1972) as a "process of delineating, obtaining, and providing useful information for judging decision alternatives." Designation of the role encumbent who is the decision maker in the organization in health care delivery and the decision making process utilized in "various circumstances" have been dependent upon a physician dominant mode. As roles (tasks to achieve goals) in health occupations are redefined in terms of needs, goals, and purposes in the health care delivery system, role expectations may include decision making by physician extenders (such as nurse practitioners) in various circumstances.

4. For each recipient of care. Expectations pertain not only to providers of care, but also to the recipients of care (patients/clients). Clientele in the health care delivery system differ in perceptions of needs, tasks, and expectations. Some factors influencing their perceptions are (a) availability of money and resources for health care, (b) the standard of culture, and (c) the values held by each recipient. These expectations influence the level of acceptance of services.

EXPECTATIONS OF PATIENTS/CLIENTS

Health Occupations Education programs have clinical components based on the modes of occupational expectations. Besides the teacher and learner, the patient/clients are third parties in clinical education. As was stated earlier, the words "various circumstances" in the definition can influence

role expectations at differing times of the day, in different decision settings, by designation of which role encumbent will judge decision alternatives, and by the expectations of the recipients of care. The selection, management, and evaluation of clinical learning experiences is the responsibility of role encumbents in the education system. The teacher in health occupations programs who has the responsibility for learning in clinical settings has to meet the expectations of (a) the health care agency in which learning was selected, (b) the educational agency in terms of learner behaviors/outcomes, and (c) the patients or clients who are receiving the care.

Health Occupations Teachers are expected to meet these expectations despite the factors and/or forces influencing their decisions such as (1) authority-responsibility relationships, (2) technological change, (3) increased demands for accountability in terms of educational gains, (4) reconciling the diminished control of selection, admission and retention practices and the increasing number of applicants, (5) accreditation/certification or licensure requirements which mandate curriculum change, (6) multiple program utilization in agencies and the need for identifying alternatives for learning such as clinical/patient management simulation, and (7) the need to provide career options.

As members of two social systems, then, teachers in health occupations education are confronted with expectation-reality gaps. These gaps can result in the following role dilemmas:

1. Role ambiguity. When the interdependence of roles is not communicated in terms of what is required and prohibited in terms of various circumstances in the job description and/or clinical agreements, there may be a discrepancy in role expectations as perceived by authority roles and the role encumbents. This can result in assuming that because an individual is

a highly proficient practitioner (member of a health care specialty) that he or she can also teach (director of learning). This dilemma can result in expectations not being defined and diminished control of accountability for the tasks to be performed by the role encumbent.

During times of change while tasks are being redefined or shuffled in order to meet the needs and serve the purposes of the organization, the ambiguity may create differing perceptions of needs. This could be in either system. During the process of implementing technological change in either system, a state of ambiguity may exist which affects the role of the teacher as director of learning and member of health care specialty.

2. Self-role conflict. This can result from factors within the teacher due to conflicting values and need-dispositions. A teacher who gets the greatest satisfaction from the role as a member of a health care specialty may use selective perception for the role as director of learning. The degree of spread (conflict) between the personal and the normative dimensions (of the model) with the resulting conflict could be influenced by the feelings of satisfaction, effectiveness, and confidence in leadership that the allied health teacher has for role encumbents in health care delivery. If teachers are to effectively teach the modes of occupational expectations, they must reconcile the roles of a health care specialty and director of learning. If the practitioner role is dominant, a greater degree of satisfaction and perceptions of efficiency and effectiveness could cause the teacher to pursue need-dispositions as practitioners rather than as teachers. This, of course, has implications for the teaching-learning process.

3. Role-goal conflicts. If the goals of role encumbents in the health care delivery system (where clinical learning takes place) are perceived to be directed toward sick-care and teachers of allied health or the

recipients of care perceive that goal to be toward well-care, a goal-role conflict could result.

4. Role expectations conflict. If perceptions of role encumbents in relation to role expectations vary from how they are perceived by others with regard to the tasks in the role, conflicts can result and as the disparity increases the potential for conflict increases. In management of learning in clinical settings, teachers in allied health programs are both practitioners and teachers. Decisions relative to priorities frequently arise with regard to responsibility for patient care and responsibility for the learner. As a practitioner, the teacher is bound by a norm for service and a code of ethics to sustain the welfare of the patient. When making decisions related to the teaching-learning process, the welfare of the patient is paramount. The authority for making decisions related to learning rests with the teacher but the authority line for the provider of care lies, not with the teacher, but a role encumbent in the health care delivery system. A conflict could result in perceptions of the roles of director of learning and facilitator of human relations. The conflict is managed frequently when the teacher, in order to facilitate human relations, makes decisions in order to accommodate the providers of care. An example is when teachers do not permit learners to take certain actions but take the action themselves.

5. Role overload. As the role encumbents try to shift priorities in order to fulfill all expectations, role overload can occur. For example, teachers in health occupations are expected to meet the role expectations as director of learning and member of a health care specialty at the same time that the expectations for the role as a member of an instructional staff are increased. Certain decisions in the educational system may be required for community service, research, and publication. At the same time, other role

expectations must also be met. Teachers in health occupations programs frequently hold leadership positions in professional organizations which help them meet their esteem needs. This expansion of role expectations as a member of a health care specialty may create demands on effort and time commitment thus producing a role overload. If the job in the educational agency is threatened, there may be a shifting from the esteem needs in the hierarchy to the survival needs.

6. Role insufficiency. Frequently, teachers in health occupations programs are selected because they are excellent practitioners and they have derived a high level of satisfaction from this role because the needs, goals, and expectations of both the normative and personal dimensions were congruent. When the teacher accepts the role of a teacher in the health occupations program where being a member of a health care specialty is one of several roles, expectations may create feelings of dissatisfaction with one or more of these roles. If teachers feel that they are being underutilized in either of the roles, their behaviors as role encumbents will be affected. Expectations of the designers of teacher education programs (either the preservice, inservice, or professional aspects) may not be the same as employers of the teachers which may also create a conflict and feelings of role insufficiency by the program completers.

Teachers in health occupations will need to learn how to manage these role conflicts.

HEALTH OCCUPATIONS EDUCATION TOMORROW

The nine categories of levels of career education based on the degree of comprehensiveness could serve as the conceptual framework for the career ladder of each of the nine curriculum spirals of the health occupations cluster. Look at these nine levels of career education. They serve as the basis for emphasis of futuristic health occupations education:

1. The teacher-learning process will focus on each learner and his/her educational needs, the learning styles, the behavior of learning, the learning environments (in and out of school) and measurement of learning outcomes based on changes in behavior and/or competencies. Emphasis will be on the helping behaviors;

2. Learning experiences will need to be provided to meet the educational needs of learners. These educational needs may be in (1) the basic human needs; (2) the several dimensions of maturity; (3) in personal, cognitive, or moral development; (4) the primary skills, or (5) secondary skills related to occupational role expectations that a worker has in relation to him/her self, to others outside the job, and to the job itself. The work behavior of health occupations education students will be greatly influenced by organizational authority-responsibility relationships and social and cultural features in the society at large; information on learners must be included in Management Information Systems and available (within constraints) to those who design learning experiences as well as to learners.

3. Learners must acquire the knowledge in the (cognitive, psychomotor, affective and perceptual domains) to meet occupational role expectations. This "expertise" in occupations is not something to acquire once and kept forever. Occupational role expectations will change with cultural, political, and economic diversity. Skills previously thought of as requiring professional competence will be redefined in accordance with the capacities of non-professional personnel. The massive growth of the collective knowledge of society will affect the domains of knowledge which undergird occupational role expectations;

4. Health Occupations Workers of the Future will need a series of life long educational experiences designed to help them meet their basic

human and educational needs and to mature; (1) to develop coping behavior in order to precent obsolescence (in the various circumstances of work and play and in understanding the world), (2) to develop clarity of relationships to society--relationships toward self, to others, and to the environment--in order that their social and learning behaviors will be self-regulated; and (3) to progress in the direction of growth in the several dimensions of maturity to establish linkages of life roles;

5. The primary skill of productive thinking will need to be provided as the levels of career education increase in the degree of comprehensiveness. Beginning with the valuing and informational dimensions of the decision maker in making health care decisions, progressing (through life-long learning) to the decision making process, the implementation of decisions, and finally to the making of public policy decisions as they relate to health occupations;

6. Since health occupations education has a clinical component where certain learning will be organized and managed in organizational structures other than in the school system, and since multiple programs in health occupations education may create demands (and competition), varied clinical learning experiences will need to be carefully selected and evaluated in terms of learning outcomes related to role expectations, the educational climate for learning, compliance standards related to safety, the role/rights of patients in health education, and alternative methods of measuring/judging competencies. Research methodology will need to address these factors in delineating, obtaining, and providing useful information for evaluation of occupational expectations and clinical competencies.

HEALTH CARE DELIVERY TOMORROW

Since there is a directional relationship between role expectations of role encumbents in the health care delivery system and health occupations education, let's look at the health care delivery system. Frey (1973), in an address on futurism in health occupations education at the Health Occupations Education Division annual meeting during the 1973 convention of the American Vocational Association, foretold a health system which would be composed of two systems of sick-care and well-care. In searching the literature, one of the best references on the topic was Health Care: Three Reports from 2030 A.D. published by the American Council of Life Insurance (1980). This report describes three emphases: (1) routine utilization of high technology medical care; (2) individual responsibility for personal health and well-being; and (3) governmental responsibility for all health problems.

Let's look again at the social behavior of role encumbents in health occupations as being in a crucible of change with a pestle of legal milestones and educational governance. Health care delivery, like education, is a social system. The social behavior (normative or personal dimensions) of role encumbents in health care delivery will be altered as change energizes the pestle of governance and legal milestones. Look at this concept in terms of four changes:

1. Graph or Curve-extension change. Two factors in society will see a growth of health workers: (1) society will expect more from the health service industry. These expectations will be based on technical and scientific progress in our society even though they result from cultural and value transmission factors. If health care is considered to be a "right" of individuals, as this belief affects the expectations of citizens, it will have real consequences in relation to roles, role expectations and social behavior of role encumbents in our society, (2) we are becoming an aging population.

HEALTH CARE DELIVERY: TOMORROW

1. Graph or curve-extension change.
2. Scientific and technological change.
3. Delivery system change.
4. Quality control.
5. Expectation-reality shock.

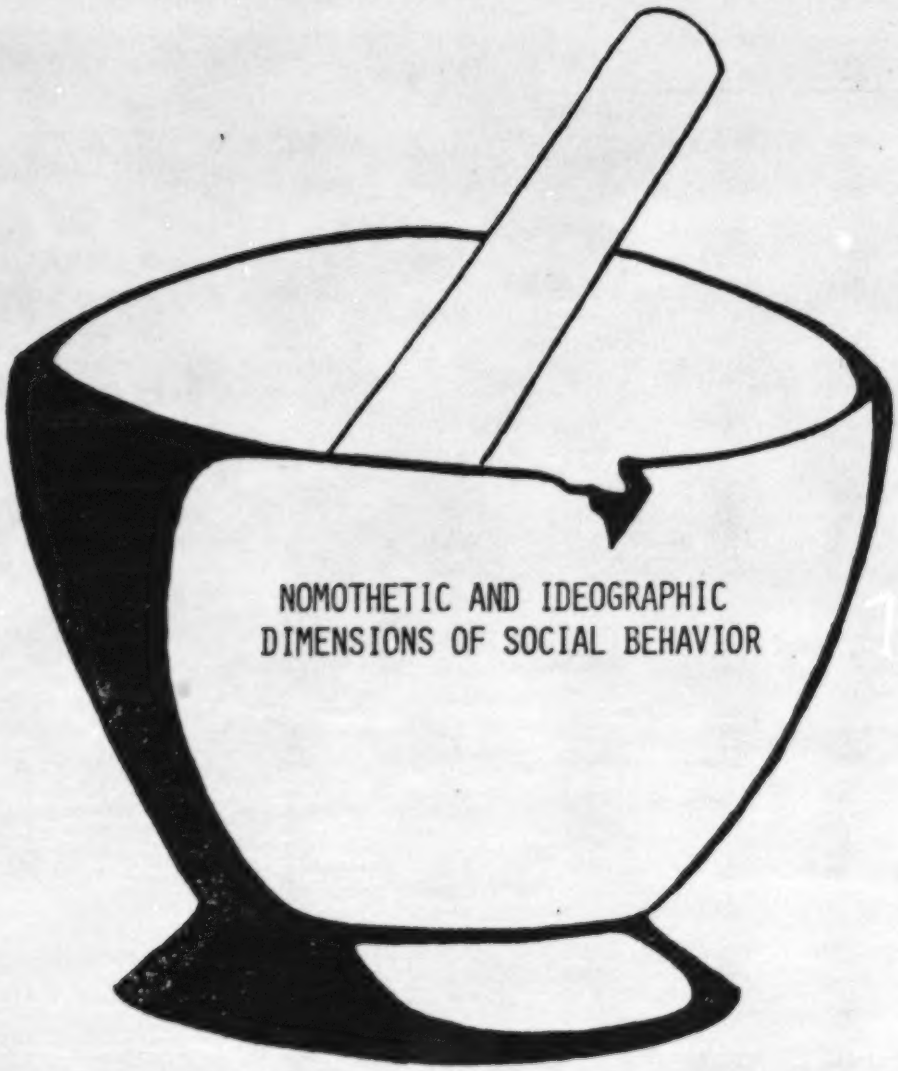
As Frey has said "older people like older machinery, will take a lot of tinkering to keep going." These factors will influence the acceptance/expectation levels of patients in surveillance vs. management care, cost-containment efforts for health care delivery, and self-responsibilities for making decisions pertaining to utilization of technology.

2. Scientific and Technical Change. Continued sophistication of medical-electronic equipment and a computerized health information system will result in greater emphasis on decisions pertaining to health and safety in all components of society such as the work place, education, transportation, and urban/rural environments. Technology will include advanced techniques for non-invasive diagnosis as well as improved quality of life.

The computerized health information system will include tele-medicine for consumers, computerized problem oriented medical record system and home computers for diagnosis and prescribing alternative plans based on the diagnosis. Self-care accessories will be available and consumers of health care will exercise freedom of choice based on health risk/benefit analyses for self-utilization of technology for health maintenance and exercise consumer choices in parenting, genetic counseling and nutrition as they relate to the technological aspects of health maintenance.

3. Delivery System Change. A health system of health maintenance and health care would energize the pestle of governance and the role expectations in each system. With regard to decision making (mentioned in the levels of career education based on degree of comprehensiveness) we presently have a physician-dominate system. The physician role as the bridge between the sick-care and well-care systems would change as physician extenders are delegated authority for decision making in "various circumstances." Pifer (1970) in describing changes in health care delivery indicated several changes in the

Pestle of legal milestones
and educational governance



THE CRUCIBLE OF CHANGE

--- EMPIRICAL - RATIONAL
--- NORMATIVE - RE-EDUCATIVE
--- POWER - COERCIVE

role of physicians including a breakdown in their professional authority. The delegation of authority to physician extenders (new role encumbents) in the health care delivery system will result in increased activities toward role recognition and legitimation. In the future the predominate role of the physician and others will be technologically diagnosing the level of wellness, establishing a wellness contract between the patient and others, and guiding the patient through the utilization of the health care delivery system.

To serve these systems of health maintenance and health care, the roles of medical records personnel, information system personnel, health sociologist, patient advocates, and health educators would need to be redefined in terms of role expectations and persons with helping and behavior modification skills (in relation to a state of wellness) will be needed.

4. Quality Control will continue to cause concern. The present system of personnel licensure, registration and certification poses real dilemmas for administrators in both education and health care delivery agencies. They are asking the question "For whom does it (the system) offer assurance of quality? The consumers of health care? or groups with vested interest? How can we continue to condone a system that bases assurances for safe practitioners on entry level according to degree or educational requirements for licensure rather than on occupational role expectations?" Further, the justification of the length of education programs by practice levels is being questioned. Futurists advocate a focus on cost containment which could be controlled through resource availability. The debate of personnel credentialing versus institutional licensure may be resolved through federal registration of all health providers based on standards for registration.

THE CRUCIBLE OF CHANGE

Look at the premises again. Health Occupations teachers are role encumbents in two social systems (education and health care delivery). They have role expectations in each system. Each system is affected by change and there is a directional relationship between change in each system. Change has been described by Etzioni (1964) based on degree of compliance. These types of change are described as normative-reeducative, empirical-rational, and power coercive. These were described as organizational change, role recognition and legitimation, and program development. This paper has described some of these types of change. An example of power-coercive change is the current nursing controversy over entry levels of practice. In this regard the following vocational organizations have taken positions against the change defined by the American Nurses' Association: (1) Health Occupations Education Dividion of the American Vocational Association; (2) the House of Delegates of the American Vocational Association; (3) National Advisory Council on Vocational Association; and (4) Association of Health Occupations Teacher Educators.

Again, look at the pestle of legal milestones and educational governance as it relates to the social behavior of role encumbents and the change process. Change could occur in either the normative or the personal dimensions of social behavior.

Jacoby (1971) has defined a social problem as a gap between society's expectations of social conditions and the present social realities and states:

> --Social expectations are the set of demands and priorities held by the people of a society at a given time. Social realities mean that set of laws, regulations, customs, and organizations, along with the persistent economic, political, and social processes that prevail at a given time.

Further, Jacoby states:

> --Social problems are created by public awareness of, or belief in, the existence of an expectation-reality gap. This is a disparity between what it should be, and what is in our society.

If society's expectation for a health care delivery system of health maintenance as well as health care are not met the disparity between the normative and personal dimensions of the social system will widen. This will, of course, affect the educational system as well.

There appear to be some similarities in the expectations of society for the educational and health care delivery system. These expectations are based on needs and are met through legislation and governance. Tasks to achieve the gaols in the social system are arranged into relevant role and the role expectations are defined. These expectations pertain to: (1) life-long learning and life-long utilization of health care services; (2) equal opportunities for all learners and access to and public responsibility for adequate health care for every citizen; (3) promotion of self-directed learning and promotion of self-responsibility for health care; (4) a management information system for making career decisions, diagnosing educational needs, and recording life-long learning and for making consumer decisions, promoting personal responsibility for decision making, and for recording life-long utilization of health care services; (5) assuming personal responsibility for participation in (a) preparatory, advanced and continuing education to meet educational needs and (b) consumer/patient education based on diagnosis of learning needs and prescriptions for learning; (6) planned intervention for role facilitation to address the expectation/reality shock when (a) practitioners become teachers, and (b) when program completers become practitioners and when individuals have life transition problems; (7) the relationship of quality control and program efficiency, design, cost, and effectiveness to (a) on the job performance of teachers and (b) clinical

competence of practitioners should be determined; and (8) alternative strategies for using curriculum materials based on characteristics of learners, learning styles, ability for self-direction and adaptation to various settings should be provided for (a) learners and (b) patient/client learners. These similarities are summarized in Table 2.

SUMMARY

The development of this paper was based on four premises: (1) health occupations education pertains to education below the baccalaureate level, is one of fifteen clusters in vocational education, and as a cluster in vocational education is an integral part of career education; (2) teachers in health occupations education are members of two professions. They are practitioners who hold credentials in health occupations and must meet the role expectations of agencies in the health care delivery system; and as professional teachers they must meet the role expectations of educational agencies; (3) health occupations teachers are members of two social systems (education and health care delivery). The social behavior of role encumbents in the educational system is based on role expectations of teachers. The social behavior of role encumbents in the health care delivery system is based on expectations for practitioners; and (4) change in either of these systems has implications for health occupations education.

Following a presentation of a theoretical model of a normative and personal dimensions of a social system, the paper focused on empirical-rational, normative-reeducative and power coercive change and the milestones and governance which have affected the social systems of education and health care delivery.

The role expectations of health occupations teachers were cited including the role as director of learning. To fulfill these role expectations, health occupations teachers must diagnose educational needs as these relate to primary

TABLE 2

SOCIETAL EXPECTATIONS FOR SYSTEMS OF EDUCATION AND HEALTH CARE

DELIVERY: SIMILARITIES IN TRENDS

Educational System	Health Care Delivery System
1. Life-long education to meet the educational needs related to primary and secondary skills for living and five life roles.	1. Life-long utilization of health care (Health Maintenance as well as primary care).
2. Equal opportunities for all learners.	2. Equal access to and public responsibility for adequate medical care for every citizen.
3. Promotion of self-directed learning.	3. Promotion of self-responsibility for health maintenance and health care.
4. A management information system for making career decisions, diagnosing educational needs, and recording life-long learning.	4. A management information system for making consumer decisions, promoting personal responsibility for decision making, and for recording life-long utilization of health care services.
5. Assuming personal responsibility for participation in preparatory, advanced and continuing education to meet educational needs.	5. Assuming personal responsibility for participation in consumer/patient education based on diagnosis of learning needs and prescriptions for learning.
6. Planned intervention for role facilitation to address the expectation/reality shock when practitioners become teachers.	6. Planned intervention for role facilitation to address the expectation/reality shock when program completers become practitioners.
7. The relationship of quality control (teacher certification) and program efficiency design, cost, and effectiveness to the on-the-job performance of teachers should be determined.	7. The relationship of quality control(individual credentialing and program accreditation) and program efficiency, design, cost and effectiveness to clinical competence of practitioners should be determined.
8. Alternative strategies for using curriculum materials based on characteristics of learners, learning styles, ability for self-direction and adaptation to educational settings should be provided for learners.	8. Alternative strategies for using curriculum materials based on characteristics of learners, learning styles, ability for self-direction and adaptation to clinical settings should be provided for patient/client learning.

and secondary skills of learning and five life roles. Secondary skills related to occupational role expectations and the life role as rendered of services were described. This framework was used to describe health occupations education and health care delivery in the contexts of today and tomorrow.

Similarities in societal expectations for the educational system and health care delivery system were described.

As members of two professions, health occupations teachers must meet the role expectations of educational agencies and as practitioners and managers of learning for occupational role expectations, they must meet the role expectations of agencies in the health care delivery system. Various role conflicts may result and they must learn to manage the conflict.

Since this is a paper on health occupations education today and tomorrow, I will make the following diagnosis. There exists today in health occupations education an expectation-reality gap! No paper on futurism would be complete without some predictions. I have two:

Through technology and application of potential wisdom, change in health care delivery is inevitable.

1. Change in either the normative or the personal dimension (role expectations) in the system of education or health care delivery will affect the social behavior of role encumbents of each system;

2. Those who counsel about, teach or administer public policy in relation to health occupations education must pay as much attention to the social, economic and political forces that determine role expectations of social behavior as to those forces that shape the realities of judging the extent to which the educational needs have been met.

I am pleased to share these thoughts with you on the tenth year of the Division of Health Occupations Education.

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